

COLLEGE OF CHARLESTON

Center for Disability Services
Phone (843) 953-1431

160 Calhoun Street

Charleston, South Carolina 29424
Fax (843) 953-7731

MEDICAL DOCUMENTATION FORM

Client/Patient: _____ Date: _____
Last Name First MI

SID#: _____ DOB: _____

Diagnosis (DSM, ICD-9, if applicable): _____

Date of Diagnosis: _____

Date(s) of Treatment and Type of Treatment Provided (i.e., medications, therapy): _____

Degree Treatment Successful: _____

Is the student currently functionally impaired by one or more of the above listed disorders?

___ YES ___ NO If yes, *specifically* describe how the disorder contributes to functional impairment(s) or limitations in an educational setting and to what degree.

Has the student experienced periods of time during which the functional impairment(s) completely (or nearly completely) remit? ___ Yes ___ No. If yes, how long are these periods on average? _____

How likely is the student to be functional impaired to the same or greater degree 30 days from now:

_____ 90 days from now: _____

6 months from now: _____ Permanently: _____

Signature and Credentials of Health Professional Date

Name and Address of Health Professional (please print or type)

Phone: _____ Fax: _____